MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION OF HEALTH STANDARDS AND LICENSURE

APPLICATION FOR STROKE CENTER REVIEW AND DESIGNATION

SECTION A

In accordance with the requirements of the Chapter 190 RSMo and the applicable regulations, this application is hereby submitted for review and designation as a stroke center. Please complete all information applicable to the requested designation level.	Designation Level Requested ☐ I ☐ II ☐ III ☐ IV

HOSPITAL INFORMATION

Name Of Hospital (Name To Appear On Designation Certificate)	Telephone Number	
Address (Street And Number)	City	Zip Code

PROFESSIONAL INFORMATION

Chief Executive Officer	Chairman/President Of Board Of Trustees
Stroke Medical Director	Stroke Program Manager
Medical Director of Emergency Medicine	Medical Director of Intensive Care Unit

RESOURCE INFORMATION

Stroke Caseload	Stroke Team Activations	CT Scan Capability ☐ FULL ☐ PARTIAL ☐ NONE	MRI Capability ☐ FULL ☐ PARTIAL ☐ NONE
Neurosurgical Capability or Transfer Plan	ICU or NICU Beds	Stroke Unit Beds	Stroke Rehab ☐ INPATIENT ☐ OUTPATIENT
Neurologists	Neurosurgeons	Neuro-Interventionalist	ED Physicians
Anesthesiologists/ CRNAs & AAs	Angiography Suites	Avg number of patients who received neuro-intervention	Avg number of patients who received thrombolytics

CERTIFICATION

We, the undersigned, hereby certify that the information provided in this application for stroke center review and designation is true and accurate; and give assurance of the intent and ability of the hospital to comply with regulations promulgated under the Chapter 190 RSMo.

We further certify that the hospital will comply with all recommendations for improvement contained in the stroke center site review reports prepared by the Missouri Department of Health and Senior Services.

Date of application_____

Signed_____
Chairman/President of Board of Trustees,
Owner, or one Partner of Partnership

Signed_____
Hospital Chief Executive Officer

Signed_____
Stroke Medical Director

Signed_____
Director of Emergency Medicine

SECTION B

Please attach the following documentation to the application form. **Name of Hospital**:

- ☐ Hospital organizational chart depicting the relationship of the stroke services to other services and defining the organizational structure of the stroke service.
- ☐ A job descriptions and CV for the stroke medical director and stroke coordinator/program manager.
- ☐ A narrative description of the administrative commitment for the stroke center, including how stroke center designation relates to the overall mission of the hospital.
- ☐ Board resolution supporting the stroke center.
- ☐ A narrative description of the catchment area for the stroke center.
- ☐ A narrative description of the prehospital system including the hospital's participation in medical control, quality assurance, and education of the emergency medicine personnel.
- ☐ Hospital diversion policy.
- ☐ List of the stroke medical director and stroke program coordinator or program manager (core stroke team) indicating the neuro-cerebrovascular related continuing education for each over the past three (3) years. (Do not send continuing education information about the clinical stroke team. This should be available at the time of the review.)
- ☐ Multidisciplinary team policy.
- ☐ List of all neurologists, neurosurgeons, neuro-interventionalists and emergency department physicians indicating stroke-related CME for each over the past three (3) years.
- ☐ List of physicians and plan for supervised relationship between Level III and higher level stroke center where stroke patients are admitted for care in a Level III center if applicable.
- ☐ Narrative description of the system for notifying/activating stroke team.
- ☐ One-call stroke team activation protocol.
- ☐ Copies of all transfer agreements pertaining to stroke.
- ☐ Policy for consultation for physical medicine and rehabilitation, physical therapy, occupational therapy and speech therapy.
- ☐ Protocols on post-discharge and post-transfer follow-up for stroke patients.
- ☐ A narrative description of the stroke quality improvement (QI) processes utilized by the hospital (Do not send copies of QI minutes or documents. These should be available at the time of review.)
- ☐ Examples of stroke-related educational, outreach, and research projects undertaken by the hospital.
- ☐ Summary of source of stroke information for Table 1 on next page.

Table 1. Ischemic Stroke Numbers for Past Two (3) Years

A	B	C	D	E
Indicate year[1] Provide two years of data	**Stroke cases**[2] / **Transfers**[3]	**Stroke cases eligible for NI**[4] / **Received NI**[5]	**Stroke cases eligible for Lytics**[6] / **Received lytics**[7]	**Stroke deaths**[8]
For example: 2007	**53** / **22**	**14** / **8**	**25** / **12**	**2**
	/	/	/	
	/	/	/	
Total	/	/	/	
Average/Year	/	/	/	

[1] Include data for the last two (2) years of hospital data. Indicate time frame in months if it is other than January to December.
[2] Include all stroke patients, independent of hospital admission or hospital transfer status. To include walk-ins, transfers, EMS transports, admitted patients, and patients that die. Include all stroke patients that have ICD-9-principal diagnosis code of 433.01, 433.10, 433.11, 433.21, 433.31, 433.81, 433.91, 434.00, 434.01, 434.11, 434.91, 436.00, 430.00 and 431.00
[3] Provide number of all stroke patients transferred to this hospital from another hospital.
[4] Provide number of stroke patients eligible for neuro-intervention (NI).
[5] Provide number of stroke patients that received neuro-intervention (NI).
[6] Provide number of stroke patients that are eligible for thrombolytics.
[7] Provide number of stroke patients that received thrombolytics.
[8] Include all deaths, ED and inpatient, independent of hospital admission or hospital transfer status.

Instructions for Completion of Application
Stroke Center Review and Designation

SECTION A

Designation Level Requested
Indicate whether the hospital is applying for designation as a Level I, II, III, or IV Stroke center.

HOSPITAL INFORMATION

Name of Hospital
Type the name of the hospital as it should appear on the designation certificate.

Telephone Number
Type the telephone number including area code for the administrative offices of the hospital.

Address
Type the street address of the hospital, including city and zip code.

PROFESSIONAL INFORMATION

Chief Executive Officer
Type the name of the Administrative Director of the hospital applying for review, not the corporate CEO.

Chairman/President of Board of Trustees
Type the name of the Chief Officer of the hospital Board of Trustees.

Stroke Medical Director
Type the name of the Stroke Medical Director, including credentials.

Stroke Program Manager
Type the name of the Stroke Program Manager, including credentials.

Medical Director of Emergency Medicine
Type the name of the Medical Director of the Emergency Department, including credentials.

Medical Director of Intensive Care/Neuro Care Unit
Type the name of the Medical Director of the Intensive Care Unit, Neuro Intensive Care or Stroke Unit to which stroke patients are admitted at the hospital, include credentials.

RESOURCE INFORMATION

Stroke Caseload
Indicate the average annual number of stroke patients seen in the emergency department and hospital calculated from the twenty-four (24) months immediately proceeding the month of application using the number from Table 1 in Section B, Column B, average/year.

Stroke Team Activations
Indicate the average annual number of times the stroke team was activated at the hospital during the twenty-four months immediately proceeding the month of the application.

Computed Tomography (CT) Scan Capability If the hospital has an in-house CT scanner that is staffed twenty-four (24) hours a day, seven (7) days a week, indicate **FULL** as the level of capability.
If the hospital has an off-campus CT scanner or one that is not staffed twenty-four (24) hours a day, seven (7) days a week, indicate **PARTIAL** as the level of capability.
If the hospital has no CT Scanner indicate **NONE** as the capability.

Magnetic Resonance Imaging (MRI) Capability
If the hospital has an in-house MRI that is staffed twenty-four (24) hours a day, seven (7) days a week, indicate **FULL** as the level of capability.
If the hospital has an off-campus MRI, or one that is not staffed twenty-four (24) hours a day, seven (7) days a week, indicate **PARTIAL** as the level of capability.
If the hospital has no MRI, indicate **NONE** as the capability.

Neurosurgical Capability or Transfer Plan
Indicate if the hospital has neurosurgical capability on-site, if not indicate if the hospital has a plan for surgical intervention.

ICU and/or NICU Beds
Indicate the total number of intensive care or neuro intensive care beds available for stroke patients at the hospital.

Stroke Unit Beds
Indicate the total number of stroke unit beds or designated stroke beds available for stroke patients at the hospital.

Stroke Rehab
Indicate if inpatient and outpatient stroke rehab is available for stroke patients at the hospital.

Neurologists
Indicate the total number of neurologists that take stroke calls at the hospital.

Neurosurgeons
Indicate the total number of neurosurgeons that take stroke calls at the hospital.

Neuro-Interventionalist
Indicate the total number of neuro-interventionalist that take stroke calls at the hospital.

ED Physicians
Indicate the total number of physicians in the emergency department participating in stroke care at the hospital.

Anesthesiologists/Certified Registered Nurse Anesthetists (CRNA) &Anesthesiologist Assistants (AA)
Indicate the total number of anesthesiologists and CRNA/AA that take stroke calls at the hospital.

Angiography suites
Indicate the total number of angiography suites available to stroke patients at the hospital.

Average number of Patients who received neuro-intervention
Indicate the average annual number of patients who received a neuro intervention calculated from the twenty-four (24) months immediately proceeding the month of the application using the numbers from Table 1 in Section B, Column C.

Average number of Patients who received thrombolytics
Indicate the average number of patients who received thrombolytic therapy calculated from the twenty-four (24) months immediately proceeding the month of the application using the numbers from Table 1 in Section B, Column D, average/year.

CERTIFICATION

Date of Application
Indicate the month, day and year the application is submitted to the Department of Health and Senior Services.

SECTION B
This section is a checklist of additional documentation that must be submitted with the application form. Please make sure all items are included and are clearly marked with the name of the hospital and attach to the application form.

Table 1. Ischemic Stroke Numbers for Past Two (2) Years

Provide data for the past two (2) years for each of the variables requested. If the data used to compile the numbers on the table are taken from a year time span that is different than a January through December time frame please indicate the time frame in months that is used, e.g., July through June, October through September.